DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center For Medicaid and State Operations, Family and Children s Health Program Group

September 13, 2002

Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Mr. Sharpe:

I am pleased to inform you that the Center for Medicare and Medicaid Operations (CMS) is approving Florida's request to renew its 1915(b) waiver know as the Medicaid Provider Access System (MediPass). I base my decision to approve the State's request on the basis that the changes will meet all statutory and regulatory requirements for the assurance of quality, accessibility, and cost effectiveness of care, as is required in all section 1915(b) waivers.

Approval of this renewal is contingent upon compliance with the attached Special Terms and Conditions. The renewal will be effective as of the first day after the end of the current authority, i.e. September 27, 2002, and will expire in two years, on September 26, 2004. We wish you continued success in the operation of the Florida MediPass program. If you have any question, please contact Ronald Reed in the Division of Medicaid and State Operations at CMS' Atlanta Regional Office at (404) 562-7429.

Sincerely,

/s/

Michael Fiore
Director
Division of Integrated Health Systems

Attachment

cc: David Rogers, MediPass Administrator
Ronald Reed, Atlanta RO
Cathy Kasriel, Atlanta RO

FLORIDA MEDIPASS 1915(B) WAIVER
SPECIAL TERMS AND CONDITIONS

1. The State shall submit to CMS on an annual basis the number of children participating in the waiver who are included in categories 1, 3, 4, and 5 of the BBA of 1997's definition of special needs children. Identification through either aid code analysis or manual review is acceptable.

2. Future presentation of the cost effectiveness analysis for each year of the look-back period and the renewal period shall separately break out with-waiver costs as follows:

a. Member months, and aggregate and PMPM costs for each major delivery system (PCCM, CMS, PSN, Healthy Start, and EPO). Within each of the above break-outs, data shall be provided by population group (TANF, SSI, SOBRA).

b. Member months, and aggregate and PMPM costs for each of the 1915(b)(3) services of Disease Management and Healthy Start wrap-around services.

c. Aggregate costs for each of the 1915(b)(3) services of Health Literacy and Frail/Elderly Program.

d. Aggregate costs for the Diabetes Pharmacy Mail Order Program.

e. Member months, and aggregate and PMPM costs for the HMO major delivery system. While the HMO delivery system is voluntary, and not authorized under this waiver, the mandatory assignment process authorized under this waiver permits the State to assign beneficiaries into the HMO. As a result, HMO member month and cost data is needed to ascertain whether adverse selection occurs. Within the HMO break-outs, data shall be provided by population group (TANF and SSI).

3. In the future presentation of the cost-effectiveness analysis, without waiver costs should continue to be provided on a PMPM and aggregate basis. The total number of member-months used to project aggregate without waiver costs should equal the sum of member months in the with waiver costs.

4. In calculating with and without waiver expenditures, the State shall account for and document the impact of state plan amendments modifying the upper payment limit for hospital services.

5. In calculating with and without waiver expenditures, the State shall account for and document the impact of utilization control measures for hospital services implemented outside the scope of this waiver.

6. In the future presentation of the cost-effectiveness analysis, savings for the look-back and renewal period shall be broken out as follows:

a. Savings attributable to each of the major delivery systems (PCCM, CMS, PSN, Healthy Start, and EPO)

b. Savings attributable to the Diabetes Pharmacy Mail Order Program.

c. Savings attributable to each of the 1915(b)(3) services of Disease Management and Healthy Start wrap-around services.

7. The State shall provide the following on-going reports to CMS:

a. Copies of quarterly reports submitted to the State by the Diabetes Pharmacy Mail Order Program vendor.

b. Annual report of total expenditures related to the Healthy Start Coordinated Care System for Pregnant Women and Infants.

c. Reports of reimbursement under the Children Medical Services Network for state plan services made to contracted providers (integrated care systems) under non-risk contracting arrangements as well as reports of cost settlements, at State Medicaid rates, for state plan services actually rendered.

8. Within 30 days of the date of this approval letter, the State shall submit a replacement page 16 that correctly reflects the provision in section 1903(m)(2)(H) of the Social Security Act which provides that the time period in which a managed care enrollee who loses Medicaid eligibility can be auto-assigned to the same plan is if the eligibility break is two months or less.

9. The State shall transition Disease Management contracts authorized under this waiver to claim federal medical assistance program match, instead of the federal administrative rate.

10. The State shall maintain funding for the Healthy Start services at a rate provided on the FY2000-01 Appropriation Act.